

KANSAS STATE BOARD OF PHARMACY

Landon State Office Building
900 SW Jackson, Room 560
Topeka, KS 66612-1256

RISK MANAGEMENT REPORT FORM

1. Reporting Party:

Name:

_____ Position: _____

Address:

(Street address and name of medical care facility)

Street

City

County

Telephone: _____

2. Pharmacist(s) involved in incident:

Name: _____ License

#: _____

3. Date of alleged incident(s): _____

4. Brief description of incident:

5. Description of sanction, corrective or disciplinary action:

6. Have preventive steps been taken?

☐ yes ☐ no

Signature of Reporting Person

This form can be faxed or mailed to:

Kansas State Board of Pharmacy
900 SW Jackson, Room 560
Topeka, KS 66612-1256

All information contained in this report is kept confidential. The reporting of this information may or may not initiate an investigation.